Charles R. Greenleaf, D.M.D.
841 N. Dean Road
Auburn, AL 36830
334-826-6651
www.auburnpediatricdentistry.com
info@auburnpediatricdentistry.com

FINANCIAL AGREEMENT

This financial obligation for your child's dental treatment is between you and our office. The insurance company is responsible to you and NOT to our office. Therefore, **IT IS YOUR RESPONSIBILITY TO UNDERSTAND ALL BENEFITS AND AGREEMENTS PERTAINING TO YOUR INSURANCE POLICY.** Once your carrier has paid the claim, you are responsible for any difference in fees and the balance will be due upon receipt of our statement. If for any reason, we have not received your insurance carrier's payment within 60 days of the date of service, the remaining balance will be due and must be paid by you.

If the account is sent to collections, 33.3% will be added to the balance. You will also be responsible for any charges incurred with collections action. You waive now and forever your right of exemption under the laws of the constitution of the state of Alabama and any other state. You agree, in order for us to service your account or to collect monies you may owe, Auburn Pediatric Dentistry and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to use.

TO OUR PATIENTS WITH INSURANCE:

As a courtesy, we will be happy to assist our patients with dental insurance by completing your claim forms and electronically filing your claim. We initially ask for a 30% payment at the time of service for any basic restorative work and 50% for any major restorative work that is completed. This includes fillings, extractions, etc. but does not include routine exams or cleanings.

Your insurance reserves the right to adjust procedure codes at their discretion and pay the lesser benefit amount. The insured is responsible for the difference after the insurance has paid the claim. Any co-pays, deductibles or differences in fees are due at the time of service.

TO OUR PATIENTS WITHOUT INSURANCE:

For our patients without insurance, the total amount on the account will be due at the time of service unless prior arrangements have been made.

By signing below, I agree that I have read and understand the policies regarding using my insurance or lack thereof as payment toward a balance due in this office.

PATIENTS NAME(S):_____

RESPONSIBLE PARTY NAME: _____

RESPONSIBLE PARY SIGNATURE:_____

DATE:_____